

Section of Psychiatry

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Community Services for the Mentally Subnormal

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Epidemiological Approach

This paper offers an epidemiological approach to the problem of providing services for the mentally subnormal, as opposed to the administrative approach presented recently in the Hospital, and Local Authority, Ten Year Plans.

The study of mental subnormality lends itself readily to the epidemiological method because, in contrast to other branches of psychiatry, diagnosis by grade, or severity of defect, can be reliably made by means of intelligence tests. Such diagnosis is inadequate for clinical purposes; but by and large it is adequate for many administrative and research purposes because the characteristics of the severely retarded – idiots and imbeciles with IQ below 50 – are, in general, qualitatively different from those of subnormal persons with IQ of 50 and above.

Recent studies of the prevalence of mental subnormality give grounds for believing that the numbers to be expected in any reasonably large catchment area can be predicted with accuracy. We can also estimate the proportion of affected cases which will present problems of management. That is, we know the size of the administrative problem.

It seems likely that we are on the threshold of a great expansion in day and residential services for the mentally handicapped. The Local Health Authorities, in particular, have during the last few years greatly increased their provision. During 1963 alone, 59 new day training centres for the subnormal were opened, containing 4,034 places. Some of these were to replace existing centres in unsatisfactory premises, of which 19, containing 994 places, were closed, so that the net increase was 40 centres providing 3,040 places. Loan sanctions for a further 39 centres (2,682 places) were issued during the year.

During 1963 the building of residential hostels also gained momentum. Twenty-eight hostels, containing 554 places for the subnormal, were opened, bringing the total of subnormal or

severely subnormal persons receiving residential care from the Local Health Authorities to 1,957. A further 31 hostels, to provide another 751 beds, were sanctioned. (In addition nearly 65,000 subnormal patients were in hospitals for the mentally subnormal.)

It seems almost certain that during the next two decades the expansion in services will continue, and that because of it, and the replacement of old units by new ones, great changes will occur.

What we suggest is that the new developments should be staged in such a way that it becomes possible to evaluate the effects of different kinds of service upon the mentally subnormal themselves, their families and the community. We have in mind, in particular, two very differing approaches to the problem of providing residential care for those defectives who need it. One alternative is to continue on the lines which are now well established, namely to provide hospital accommodation for patients in large comprehensive units of the kind that we are all familiar with. The second alternative is through the provision of small boarding units (Tizard 1964, Community Services for the Mentally Handicapped. London).

The expansion of services provides an opportunity to introduce on a properly planned, experimental basis different kinds of service in different areas. If this is done, and if means can be found to evaluate the effects of different kinds of service, something of the nature of a clinical trial of services, similar in some respects to the clinical trial of a new drug or alternative forms of treatment, may be envisaged. The need for this is very great since so little is known about the efficacy of different forms of treatment, types of care, and varieties of special education.

Is such a study possible, and if so, how could it be launched? As a first step there should be established several experimental areas in which different types of service would be tried out and their effects evaluated. Each experimental area should be small enough to cope with all the problems of the mentally sub-normal who do not require in-patient treatment without involving them or their families in excessive travelling. For

those who require residential care two main types of provision are envisaged: one on traditional lines using the network of residential services which have developed over the years, the other a small area-based service which attempts to meet the needs of all those mentally subnormal persons within the catchment area through a system of interlocking day and residential units.

Several studies involving small and large units should be undertaken, and their effects compared. Some co-ordination between the workers taking part in the different studies would obviously be essential, but it would be sufficient if several groups of workers could agree to collect certain basic data in a form which would make comparisons possible.

In any such trial much attention would have to be paid to the criteria by which the effects of different types of service would be measured. Among these may be mentioned: (1) The problem of diagnosis and the assessment of change. For many aspects of development there already exist well-standardized, usable tools by which these functions could be assessed. They include intelligence tests, various tests of language, tests of social competence, measures of job success. (2) Criteria must be developed for assessing the effects of the handicap and of the services upon the families concerned. Here, too, during the last few years, research workers concerned with the problems of social and clinical psychiatry have made considerable progress in the definition of such problems, and it is probable that operational criteria could be arrived at without too much difficulty. (3) There are economic and administrative considerations. Collaboration would need to be sought with departments of social administration.

No single criterion can be found which would enable a decision to be made as to which pattern of service was 'best'. We must consider instead a multiplicity of factors, measure each of these as accurately as possible, and decide on the basis of the information we gather which of the alternatives our society prefers. This is not so very different from the problem that confronts the investigator who is concerned with the clinical trial of different forms of treatment. We tend to think of the outcome of a clinical trial as something which can be measured on a single scale from best to worst. More often, however, we are faced with side-effects of various sorts and with a complex of factors which vary independently, so that after the last analysis has been made, a decision has to be taken. This is particularly true when we are considering not treatments which cure a disease without leaving after-effects, but measures such as leucotomy or certain kinds of drug treatment which alleviate some symptoms,

perhaps make others worse, and do not essentially alter the course of the illness.

Objections can always be brought against proposals for new ways of doing things. Those who consider that in principle the kind of experiment outlined cannot give working answers to questions of social policy would do well to look at other fields in which similar research has been carried out. A notable example is in Sweden where a seven-year experiment was conducted in Stockholm to decide whether comprehensive schools offered greater advantages to pupils of secondary school age than the equivalent of our grammar and modern schools. The city was divided into two halves, one of which tried one system, while the other continued with the existing system. The results were carefully evaluated, and on the basis of the findings an administrative decision in favour of one type of schooling was made. The complexity of the issues was probably as great as would be encountered in the evaluation of a mental deficiency service, yet an answer was arrived at. We think an answer could be found here also.

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A Plan for Experimental Evaluation

The medical, psychiatric, psychological, educational, training and recreational needs of the subnormal living at home are being met by a combination of: general practitioner; Regional Hospital Board; Local Health Authority and Local Educational Authority provisions serving catchment areas within the Hospital Region. However, when for various reasons the subnormal patient is in need of residential care, he is often 'exported' out of the area where his family lives to a hospital for the subnormal or a registered private home serving a much larger catchment area of between 250,000 and 500,000 people. These institutions are therefore often large and many are situated in isolated rural areas. They often provide on one site for children and adults of all grades of defect. In addition to providing residential care they also make available their own separate services to meet the patients' medical, psychiatric, custodial, educational, training and recreational needs. Most of these residential facilities were administered by Local Health Authorities until 1948, when they were taken over by the Regional Hospital Boards. Some Boards (like the Wessex Board) found in 1948 that the LHAs within their borders had not sufficient